		CSB-1111 (b)
Section: CFC/PAS Person Centered Planning	**Subject: PERS Referral Form (sample) DPHHS SLTC-241**	

AGENCY NAME - ADDRESS
PHONE NUMBER - FAX NUMBER

COMMUNITY FIRST CHOICE PERS REFERRAL

- Plan Facilitator Name: _____

CFC Referral ☐ CFC Amendment ☐ Change CFC PERS Provider ☐ Service Termination ☐

This is to notify you that the member named below has chosen a Personal Emergency Response System from you.

PERS Provider: _____Provider Medicaid ID# _____

Member Name: _____

Member Phone Number: _____

- Member Medicaid ID# _____
- Member Birth Date_____

Address: _____

Physician: _____ Phone No: _____

Primary Diagnosis: _____ Diagnosis Code: _____

Prior Authorization#: _____ Date Span: _____

Service	Procedure Code	Mod	Current Units	Corrected Units	Rate	Effective Date

Comments:

Notification of Service Termination:

_____ _____
PERS Provider Termination Date

_____ _____
Member Name Date